Budget 2016
ACFI Modelling - Summary Findings
June 2016

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3. Introduction

Background

The Aged Care Funding Instrument (ACFI) is the mechanism used to allocate Government funding to meet the care needs of permanent residents living in Commonwealth approved residential aged care facilities.[1]

First introduced in March 2008, ACFI is described as a resource allocation instrument that focuses on key areas of care need as a basis of appropriating funding for residents. ACFI measures core care needs that are required on a regular basis. These aspects are then used to measure the average cost of care in longer stay environments.

Based on the differing resource requirements of individual residents, ACFI is primarily intended to deliver funding to the financial entity providing the care environment.

ACFI consists of 12 questions about assessed care needs, each having four ratings (A, B, C or D) and two diagnostic sections. While the ACFI questions provide basic information that is related to fundamental care need areas, it is not a comprehensive assessment package. Further information regarding ACFI is provided at Appendix Two.

Reductions in the funding of aged care was first formerly signalled in the Mid-Year Economic Fiscal Outlook (MYEFO 2015). Cutbacks to ACFI, totalling close to $1.2 billion over the next four years, were announced as part of Scott Morrison's 2016-17 Federal budget in May 2016.[2]

The Government reports that expenditure on ACFI would be expected to blow out by $3.8 billion over the next four years without action. The response is significant with amendments to "certain aspects" of the ACFI funding model aimed to "stabilise higher than expected growth".[3]

The Government hopes that the cuts will bring the ACFI funding back into the budgeted growth trend so that "funding grows at a responsible and sustainable rate". [3]

Project Scope

UnitingCare Australia engaged Ansell Strategic to undertake an analysis of the impacts of the proposed funding changes. With the support of Aged & Community Services Australia and Catholic Health Australia, a comprehensive survey has been conducted with input from Not-for-Profit providers across the country.

Participants of the survey submitted details of their current claims and have contributed feedback on the implications to their services and the people they care for. The information has been used to model the financial and qualitative impacts of the funding changes on the Not-for-Profit sector and the industry as a whole.

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[1] Aged Care Funding Instrument User Guide
[2] Australian Government Budget 2016-17 Budget Paper No. 2 Part 2: Expense Measures
[3] Australian Government Budget 2016-17 Portfolio Budget Statements 2016-17 Budget Related Paper No. 1.10 Health Portfolio.

The modelling contains responses from 501 homes across Australia and the ACFI profile information for almost 39,000 residents, making it the largest study on the impact of the announced reforms.

The findings have been used to present recommendations on the establishment of more sustainable funding models for the future.

4. Changes to ACFI Funding

The Federal Government announced changes to ACFI with a focus on the Complex Health Care (CHC) domain. As highlighted above, CHC includes medication assistance, pain treatments and other care interventions for the frailest residents living in residential care. The changes will be implemented in two stages over the coming six months.

Changes to the CHC Domain (July 1, 2016 and January 1, 2017)

Date	**Changes to the CHC Domain**
July 1, 2016	Changes to the CHC domain scoring matrix Indexation halved for the CHC domain
January 1, 2017	New CHC matrix scoring for Question 11 (Medications) Reduced scoring and eligibility criteria changes for some CHC treatments

Source: Department of Health Fact Sheet – Changes to Residential Aged Care Funding Arrangements

The changes will only affect new or reclassified residents. Given that residents included in the CHC domain are generally the most frail and have short lengths of stay, it is anticipated the changes will affect most providers within a short period of time.

July 1, 2016 Changes

The existing CHC scoring matrix comprises both medication assistance and complex care treatment domains.

Current CHC Domain

Medications Complex Care	**No Complex Care**	**Low Complex Care**	**Medium Complex Care**	**High Complex Care**
Nil Medications	Nil ($0)	Nil ($0)	Medium ($46.27)	Medium ($46.27)
Less than 6 minutes of medication assistance	Nil ($0)	Low ($16.25)	Medium ($46.27)	High ($66.82)
Between 6 and 11 minutes of medication assistance	Low ($16.25)	Low ($16.25)	Medium ($46.27)	High ($66.82)
More than 11 minutes of medication assistance	Low ($16.25)	Medium ($46.27)	High ($66.82)	High ($66.82)

Source: Department of Social Services Subsidies and Supplements March 20, 2016

The proposed tool results in the "downgrade" of two categories in the CHC domain:

- Score for a rating of D in Question 11 (Medication) and a C in Question 12 (CHC) will be reduced from 3 points to 2 points; and
- Score for a rating of A in Q11 and a C in Question 12 will be reduced from 2 points to 1 point.

Proposed CHC Domain Matrix July 1, 2016 to 31 December, 2016

Medications Complex Care	No Complex Care	Low Complex Care	Medium Complex Care	High Complex Care
Nil Medications	Nil ($0)	Nil ($0)	**Low ($16.25)**	Medium ($46.27)
Less than 6 minutes of medication assistance	Nil ($0)	Low ($16.25)	Medium ($46.27)	High ($66.82)
Between 6 and 11 minutes of medication assistance	Low ($16.25)	Low ($16.25)	Medium ($46.27)	High ($66.82)
More than 11 minutes of medication assistance	Low ($16.25)	Medium ($46.27)	**Medium ($46.27)**	High ($66.82)

Source: Department of Health Fact Sheet – Changes to Residential Aged Care Funding Arrangements

January 1, 2017 Changes to Medication Scoring

Current ACFI funding for medication assistance is based on the time spent assisting residents with the administration of medications. Four categories, ranging from "no assistance with medications" to "more than 11 minutes assistance per day" classify the care requirements of each resident. Currently residents who require over 11 minutes each day or who receive regular injections are considered to have "high" care needs. Over 40% of residents fall into this classification Australia wide.

Current ACFI11 Average Medication Classifications Australia Wide

	Nil	Low (<6 mins/day)	Medium (6 to 11mins/day)	High (>11 mins/day)
ACFI Medication (Current)	2.18%	24.70%	31.73%	41.40%

Source: Department of Social Services ACFI Monitoring Report November 2015

Changes announced by the Department of Health (DoH) following the 2016-17 budget have described a new system for classifying medication assistance. The new classification will be reduced to three ratings based on the requirement for assistance, not the time taken to assist the resident. Residents will either be classified as requiring:

- No assistance needed with medications;
- Assistance needed with medications; or
- Injections (subcutaneous, intramuscular, intravenous).

January 1, 2017 Changes to CHC Scoring and Eligibility

From July 1, 2017 changes will also be made to the scores and eligibility requirements for some complex care treatments:

Changes to CHC Procedures from January 1, 2017

Affected CHC Treatment	Change to Scoring and Eligibility
12.1 Blood Pressure Measurement	Score reduced from 3 points to 1
12.4A Complex Pain (at least weekly and for 20 minutes)	Score reduced from 3 points to 2
12.4B Complex Pain (by allied health professional at least 4-times per week)	Score reduced from 6 points to 4 Must be at least 120 minute duration per week
12.2 Management of oedema, DVT, arthritis or chronic skin conditions	Score reduced from 3 points to 1 where the treatment is for the management of arthritic joints and arthritic oedema involving the application of tubular elasticised support bandages

Source: Department of Health Fact Sheet – Changes to Residential Aged Care Funding Arrangements

Data from the Department of Social Services (DSS) shows that 44.59% of residents are currently receiving an overall high CHC score. The majority of these residents receive treatments to alleviate pain.

Current Average CHC Classifications

Complex Care Medications	No Complex Care	Low Complex Care	Medium Complex Care	High Complex Care
Nil medications	Nil 0.90%	Nil 0.34%	Medium 0.81%	Medium 0.13%
Less than 6-minutes of medication assistance	Nil 4.25%	Low 7.17%	Medium 7.11%	High 6.17%
Between 6 and 11 minutes of medication assistance	Low 7.12%	Low 6.23%	Medium 8.74%	High 9.64%
More than 11 minutes of medication assistance	Low 3.00%	Medium 9.75%	High 21.15%	High 7.50%

Source: Department of Social Services ACFI Monitoring Report November 2015

5. Findings

Survey Response

Surveys were forwarded to member organisations of UnitingCare Australia, Catholic Heath Australia and Aged Care Services Australia. Members were requested to submit responses within one week.

Responses were submitted from over 500 homes, providing detail of over 21% of the total number of permanent residents in residential aged care[4].

Survey Responses by State

Region	No. Facilities Responded	Average Facility Size	No. of Residents in Survey	% of All Residents
ACT	9	75.4	679	32.85%
NSW	240	81.2	19,332	31.24%
NT	-	-	-	0.00%
QLD	92	77.0	7,085	22.06%
SA	32	86.8	2,863	16.92%
TAS	11	73.5	809	17.63%
VIC	63	74.4	4,688	9.97%
WA	54	60.5	3,267	21.72%
Total	**501**	**77.3**	**38,723**	**21.48%**

Close to 73% of the homes surveyed were located in metropolitan areas. Of the 142 homes surveyed in regional, rural and remote areas, only 22 (15.5%), received a viability supplement. These homes are typically small with an average bed size of only 30 beds per facility.

Survey Responses by Remoteness

Region	No. Responses	No. of Residents	No. Homes Receiving Viability Supplement	No. Residents Receiving Viability Supplement
Metropolitan	359	28,264	0	0
Regional, Rural & Remote	142	10,459	22	662
Total	**501**	**38,723**	**22**	**662**

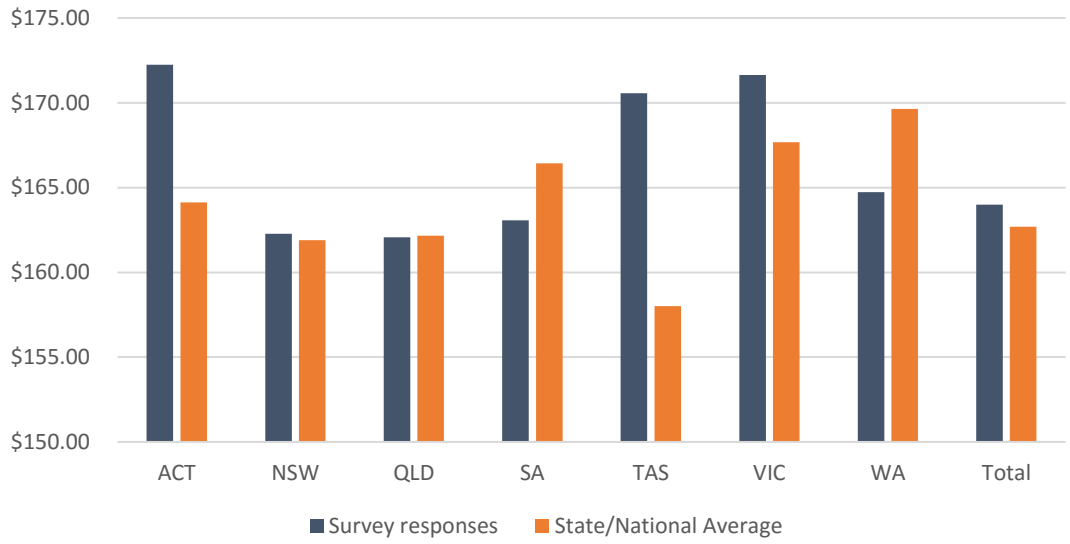
[4] Total number of residents calculated as average occupancy x allocated places. Average occupancy (92%) from Aged Care Financing Authority Report on the Impact of the 1 July 2014 Financial Reforms on the Aged Care Sector. Number of allocated places (195,193) from Department of Social Services Aged Care Stocktake of Australian Government Subsidised Aged Care Places and Ratios as at 30 June 2015.

Current ACFI Claiming Practices

Current ACFI claims are largely in line with state and national figures produced by the DoH. Tasmania and the ACT were the only exceptions where smaller group numbers may have skewed results.

The average ACFI subsidy of the not-for-profit survey respondents was $163.99 per resident per day. The survey group is currently making claims slightly above the national average of $162.69.

Average ACFI Claim ($) Per Resident per Day

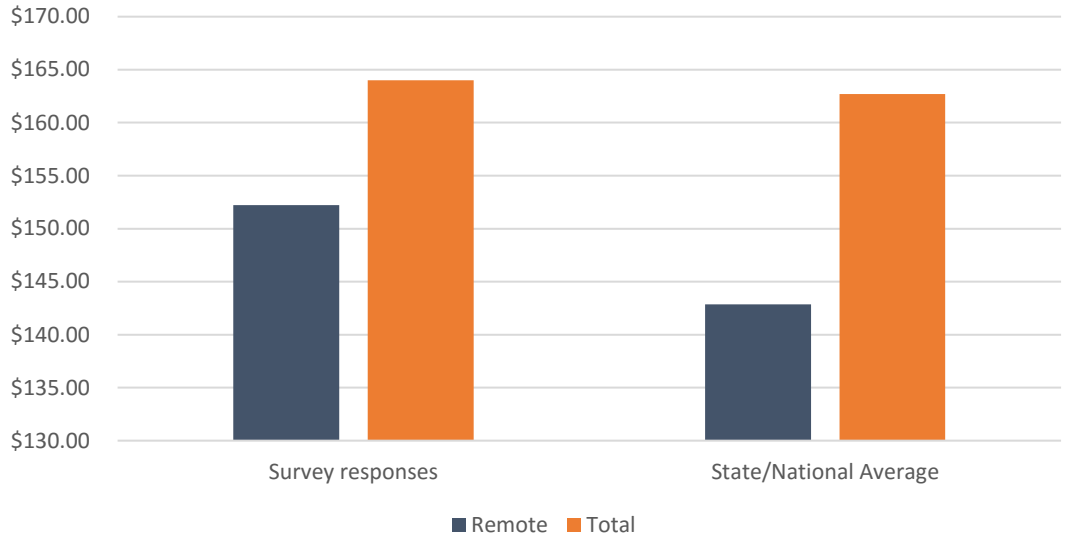


Average ACFI Claim ($) Per Resident per Day

Region	Survey Average	State/National Average
ACT	$ 172.25	$ 164.12
NSW	$ 162.28	$ 161.89
QLD	$ 162.06	$ 162.16
SA	$ 163.07	$ 166.42
TAS	$ 170.57	$ 158.01
VIC	$ 171.65	$ 167.68
WA	$ 164.74	$ 169.64
Rural & Remote	$152.59	$142.85
Total	**$ 163.99**	**$ 162.69**

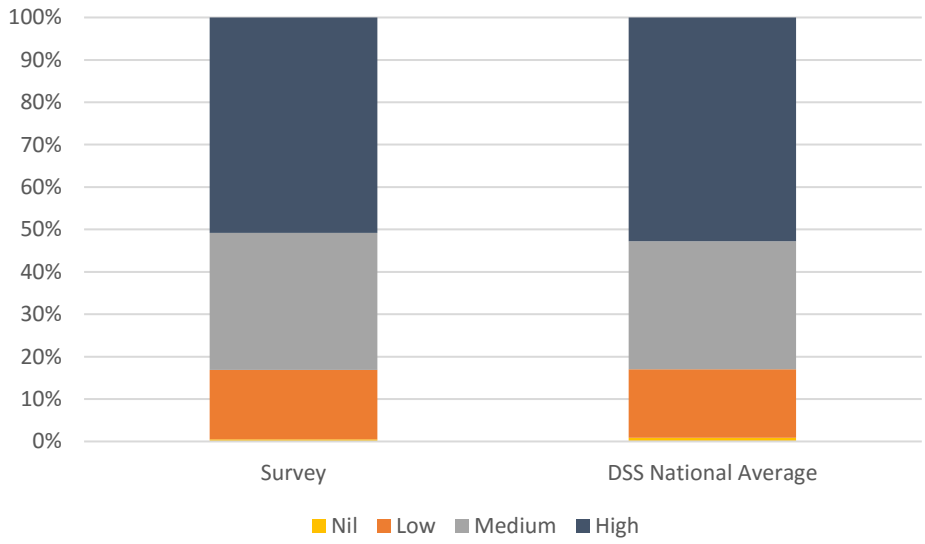
Rural and remote homes have significantly lower ACFI claims than their metropolitan counterparts. Remote homes claim an average of $152.59 per resident per day, $10.10 less than the national average of $162.69.

Average ACFI Claim ($) per Resident per Day (Rural and Remote)



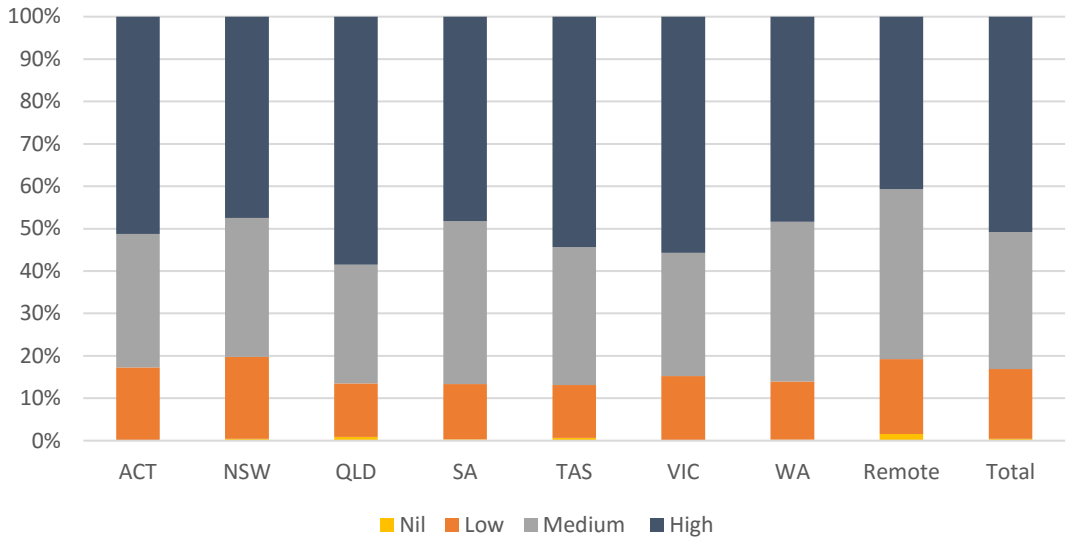
Claims for high levels of assistance with ADLs are consistent throughout all states and the national average. Less than 1% of all residents have no or minimal assistance with ADLs. 50.8% of all residents included the survey require significant assistance with ADLs.

Average ADL Claims – Survey Group vs. DSS National Average



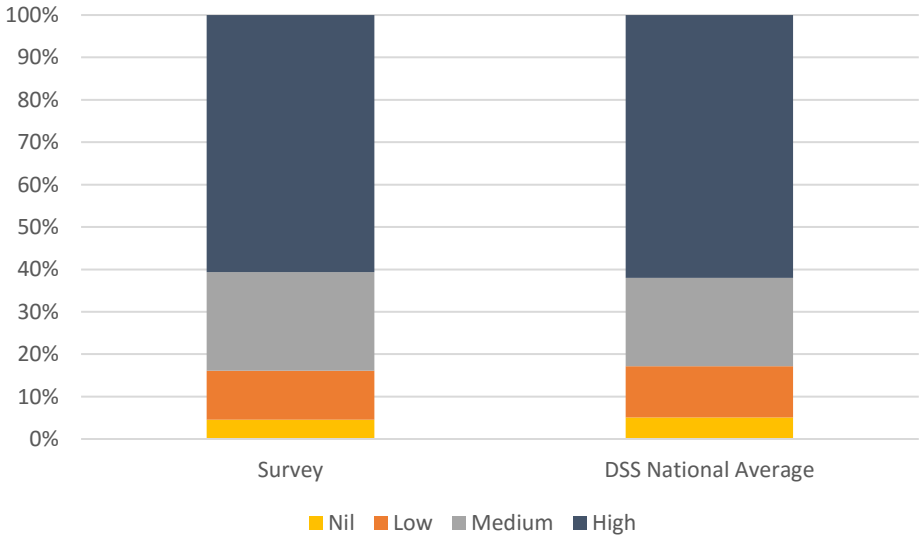
ADL claims vary from state to state. Notably, remote homes have a higher number of residents with low ADL needs, indicating that the homes either care for residents with lower care needs or that claiming practices are not in line with metropolitan counterparts.

Average ADL Claims - State and Remote vs. DSS National Average

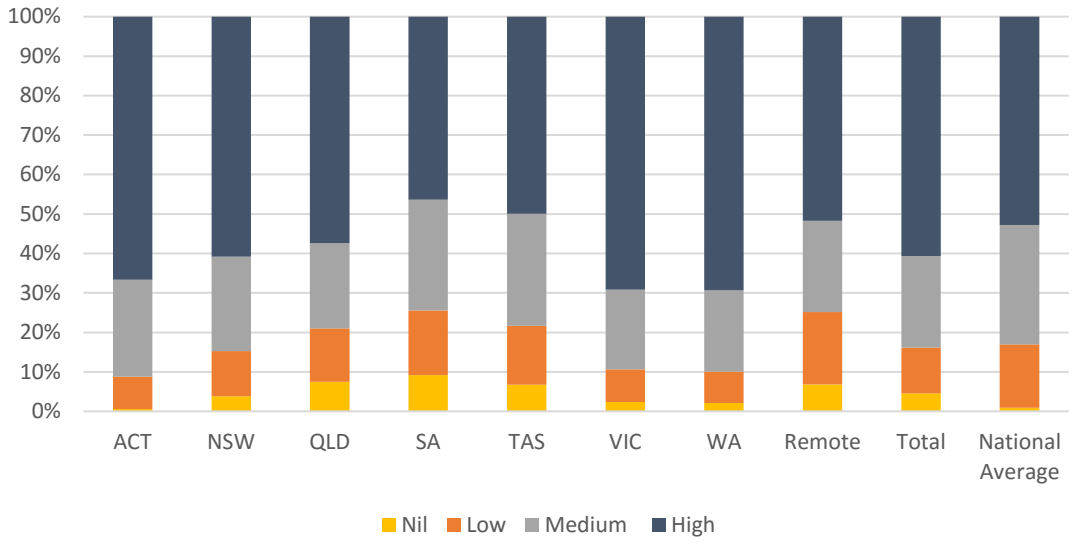


There are large variances in behaviour claims from home to home and state to state. The average of the total survey group is, however, in line with national averages produced by the DSS. Variances in claims are largely reflective of each home's philosophy and capacity to care for residents with dementia and other behavioural disturbances.

Average Behaviour Claims – Survey Group vs. DSS National Average

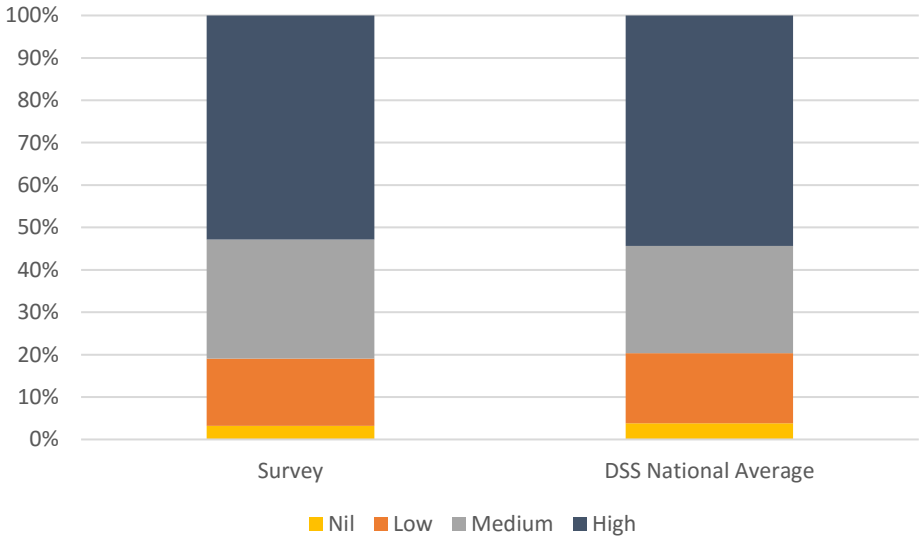


Average Behaviour Claims - State and Remote vs. DSS National Average

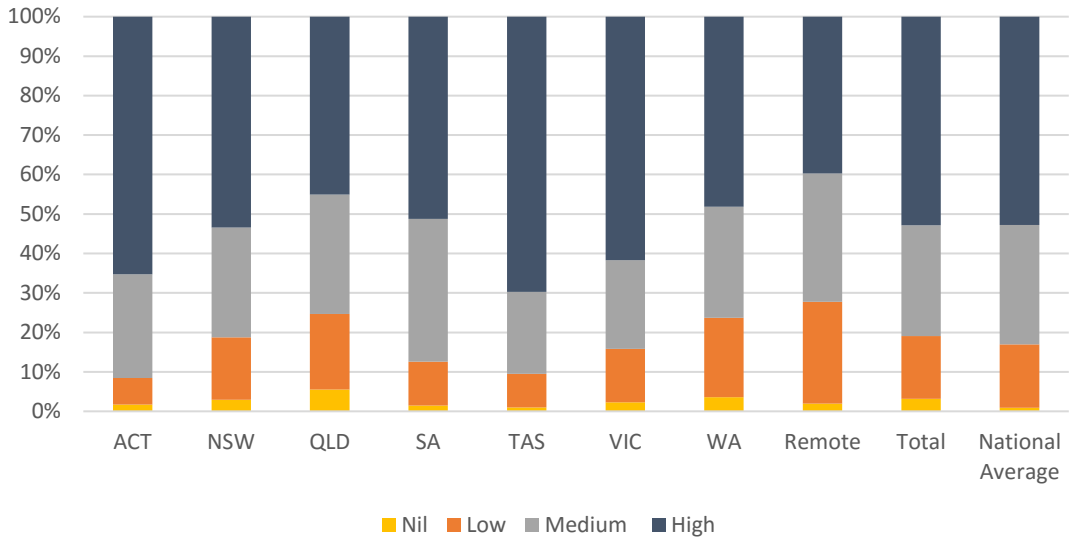


CHC claims also vary significantly from home to home and state to state. The average of the total group is again in line with national averages produced by the DSS suggesting that the survey group is an accurate reflection of the national profile.

Average Behaviour Claims – Survey Group vs. DSS National Average



Average Complex Health Care Claims - State and Remote vs. DSS National Average



Existing CHC claims are relatively consistent with results published by the DSS. It is important to highlight that although overall scores are comparable between the survey and national groups, the not-for-profit survey group are making higher numbers of claims for residents with both high medication and high complex care treatments.

Average Pain Complex Care Claims

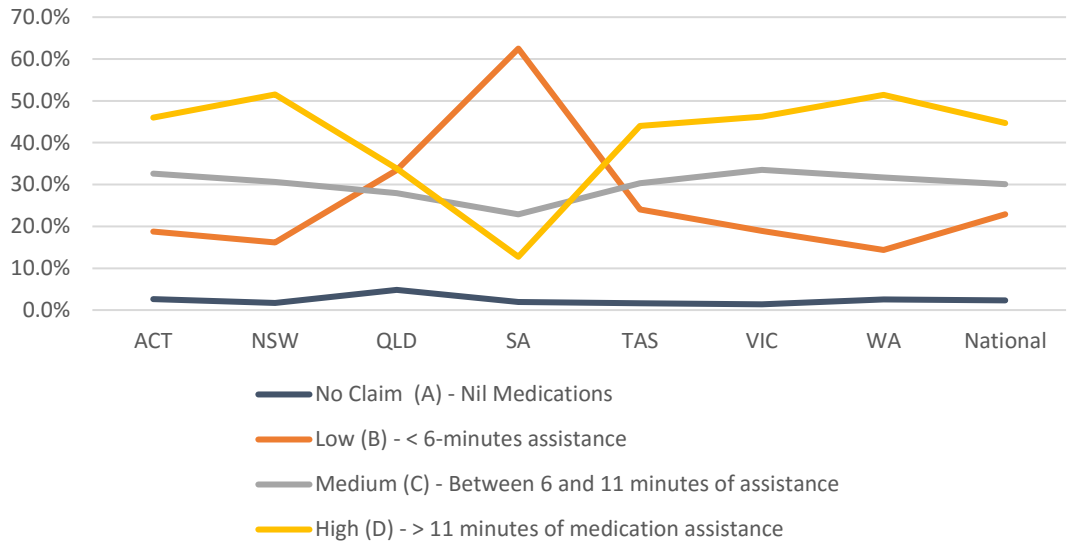
Complex Care Medications	No Complex Care	Low Complex Care	Medium Complex Care	High Complex Care
Nil Medications	Nil ($0) DSS 0.64% Survey 0.75%	Nil ($0) DSS 0.25% Survey 0.26%	Medium ($46.27) DSS 0.94% Survey 0.89%	Medium ($46.27) DSS 0.16% Survey 0.40%
Medication assistance < 6 mins	Nil ($0) DSS 2.92% Survey 2.19%	Low ($16.25) DSS 5.47% Survey 6.51%	Medium ($46.27) DSS 7.12% Survey 7.58%	High ($66.82) DSS 8.52% Survey 6.62%
Medication assistance between 6 and 11 mins	Low ($16.25) DSS 5.17% Survey 3.12%	Low ($16.25) DSS 4.65% Survey 4.23%	Medium ($46.27) DSS 8.29% Survey 9.87%	High ($66.82) DSS 12.02% Survey 12.88%
> 11 mins of medication assistance	Low ($16.25) DSS 1.89% Survey 2.00%	Medium ($46.27) DSS 8.15% Survey 9.75%	High ($66.82) DSS 25.09% Survey 22.95%	High ($66.82) DSS 8.72% Survey 10.00%

Current claims for medication assistance are largely in line with national figures. South Australian submissions are the only exception, where claims are much lower than all other states. This is mainly a result of the large number of surveys being submitted by a small number of organisations with multiple homes.

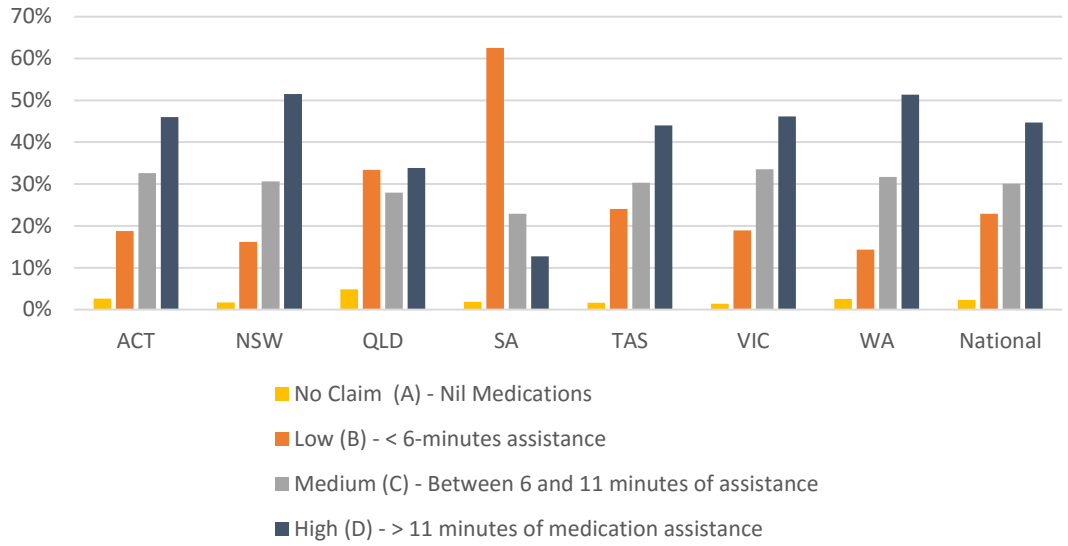
Average Medication Claims

Region	No Claim (A) Nil Medications	Low (B) < 6minutes assistance	Medium (C) Between 6 and 11 minutes of assistance	High (D) > 11 minutes of medication assistance
ACT	2.6%	18.8%	32.6%	46.0%
NSW	1.7%	16.2%	30.6%	51.5%
QLD	4.8%	33.4%	28.0%	33.8%
SA	1.9%	62.5%	22.9%	12.7%
TAS	1.6%	24.0%	30.3%	44.0%
VIC	1.4%	18.9%	33.5%	46.2%
WA	2.5%	14.4%	31.7%	51.4%
Total	**2.3%**	**22.9%**	**30.1%**	**44.7%**

Average Medication Claims



Average Medication Claims

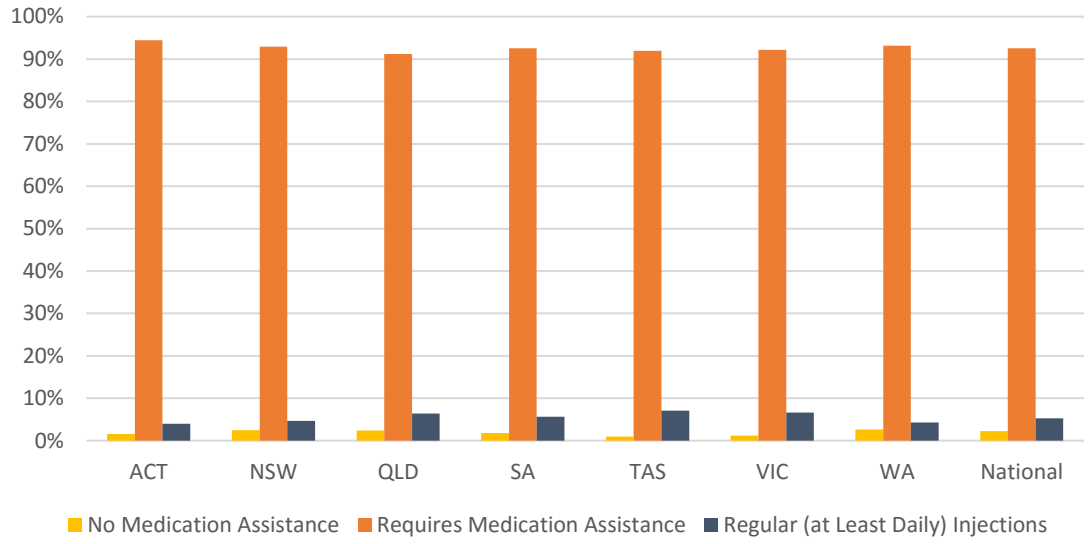


Survey respondents were asked to indicate if residents required assistance with medications. Results demonstrate that residents overwhelmingly require assistance with medications with over 97.8% of residents included in the survey requiring assistance with medications at least daily. These findings are consistent with current ACFI claims. Only 5.3% of residents require assistance with injectable medications at least daily.

Medication Assistance Requirements

Region	No Medication Assistance	Requires Medication Assistance	Regular (at Least Daily) Injections
ACT	1.6%	94.4%	4.0%
NSW	2.5%	92.9%	4.6%
QLD	2.4%	91.2%	6.4%
SA	1.8%	92.6%	5.6%
TAS	1.0%	91.9%	7.1%
VIC	1.2%	92.2%	6.6%
WA	2.6%	93.1%	4.3%
Total	**2.2%**	**92.5%**	**5.3%**

Medication Assistance Requirements



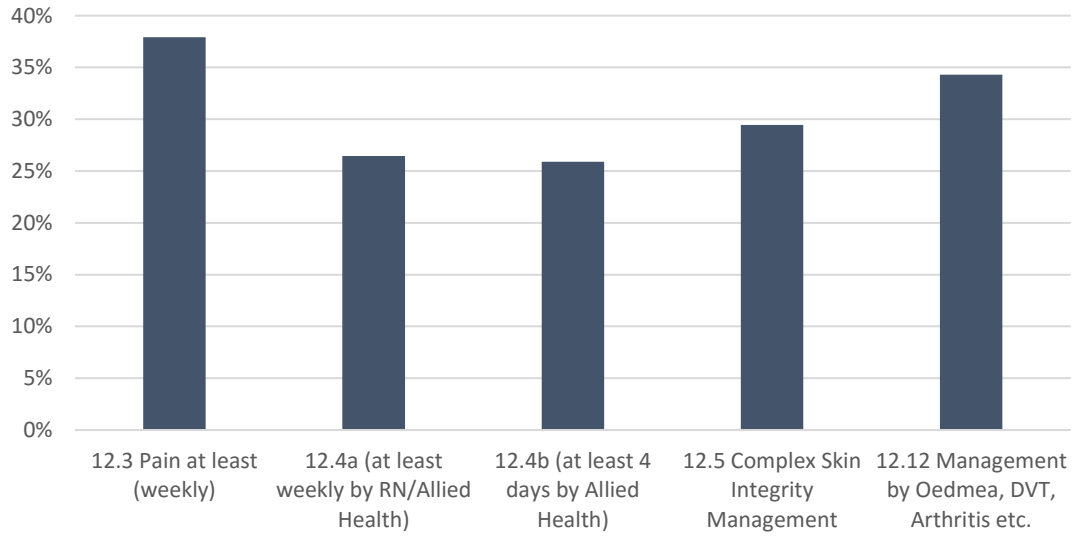
Residents included in the survey require a large number of CHC treatments. There is no comparable data published by the DSS or DoH detailing the actual incidents of CHC treatments.

Average CHC Treatments

CHC Treatment	Average No. Per Facility	Percent
12.1 Daily BP	2.73	3.55%
12.2 Daily BGL	5.02	6.52%
12.3 Pain (At Least Weekly)	28.45	36.94%
12.4a Pain (at least weekly by RN/Allied Health)	21.22	27.56%
12.4b Pain (at least 4-days by Allied Health)	20.00	25.98%
12.5 Complex Skin Integrity Management	22.42	29.11%
12.6 Special Feeding by RN	0.23	0.30%
12.7 Administration of Suppositories	0.43	0.56%
12.8 Catheter Care Program	2.01	2.62%
12.9 Chronic Infection Management	1.41	1.84%
12.10 Management of Chronic Wounds	4.89	6.35%
12.11 Management of IV, Syringe Drivers or Dialysis	0.14	0.18%
12.12 Management of Oedema, DVT, Arthritis etc.	27.25	35.39%
12.13 Oxygen Therapy	1.38	1.79%
12.14 Palliative Care Program	0.58	0.76%
12.15 Stoma Care Management	0.74	0.96%
12.16 Tracheostomy Care	0.04	0.06%
12.17 Tube Feeding Management	0.35	0.45%
12.18 CPAP Management	0.52	0.68%

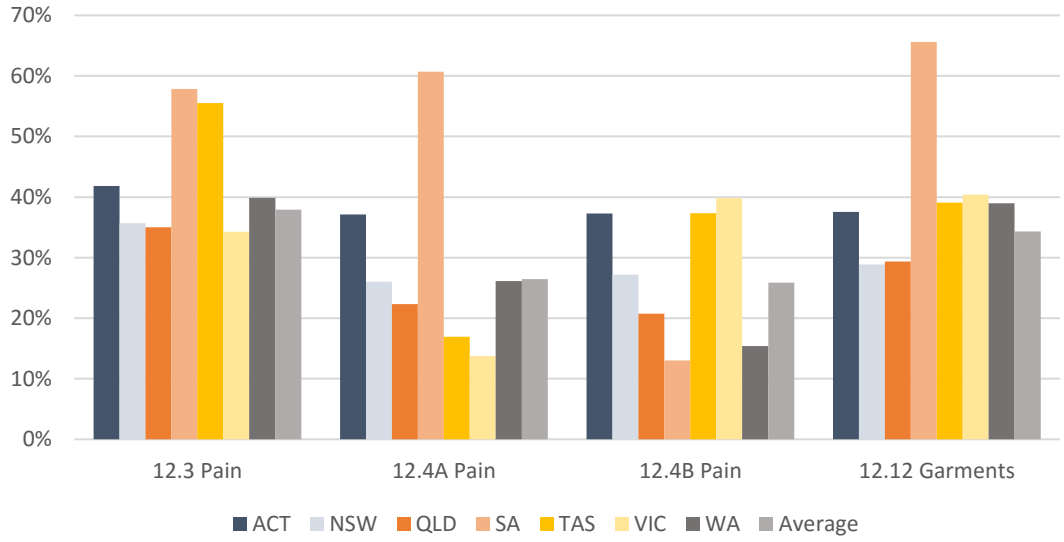
The highest number of claims relate to pain treatments, skin integrity management and the management of oedema, arthritis, deep vein thrombosis (DVT) or skin conditions with the use of elasticised or pressure garments.

Average Pain and Pressure Garment Claims



Claims relating to pain treatments and the application of pressure garments vary greatly from facility to facility with use ranging from 0% to 100% in some homes. Treatment claims also vary greatly between states.

Average Pain and Pressure Garment Claims by State



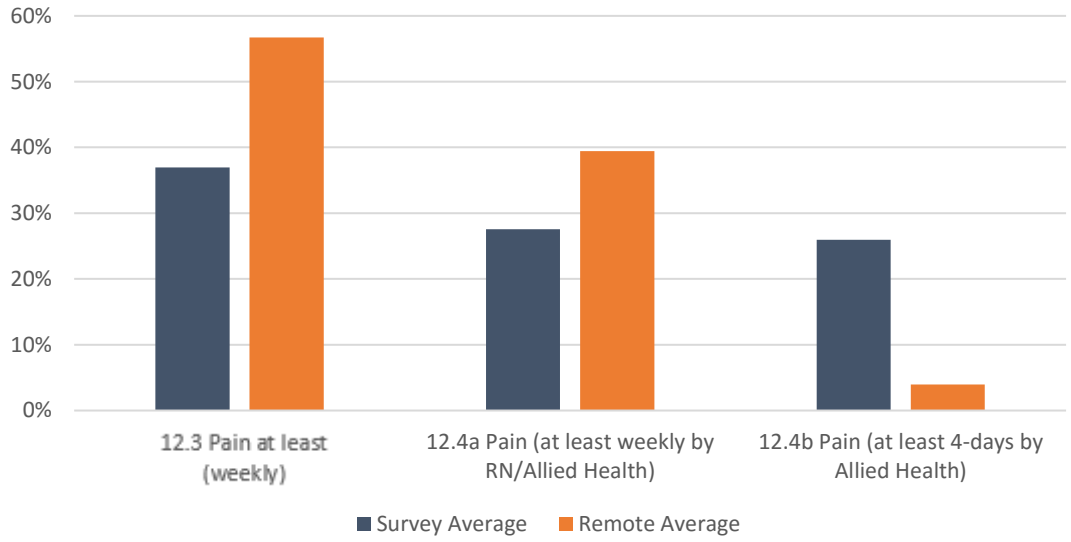
Most notably, the use of 12.3 pain and 12.4a pain treatments that can be undertaken by Carers is significantly higher in remote areas but the use of 12.4b pain treatments is almost non-existent, demonstrating that remote homes are reliant on care and nursing staff to undertake pain treatment. This is largely a result of limited access to allied health staff in

remote areas and the large cost associated with the recruitment of an allied health practitioner to service a small home.

Average Pain Claims – Total Survey vs. Remote

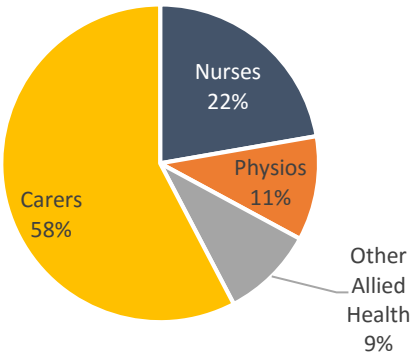
CHC Treatment	Survey Average	Remote Average
12.3 Pain (at least weekly)	36.94%	56.73%
12.4a Pain (at least weekly by RN/Allied Health)	27.56%	39.44%
12.4b Pain (at least 4 days by Allied Health)	25.98%	3.94%

Average Pain Claims – Total Survey vs. Remote

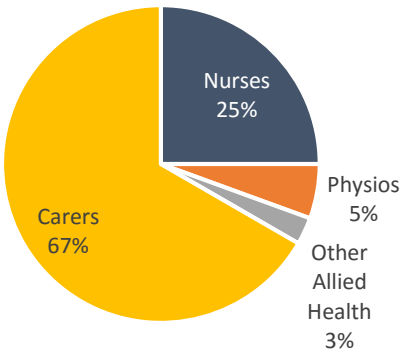


12.3 Pain Treatment Delivery (At Least Weekly)

Total Survey

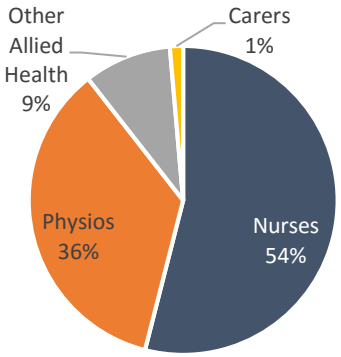


Remote

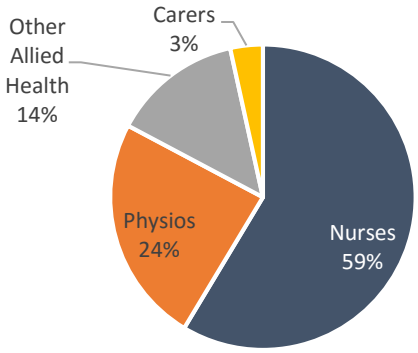


12.4a Pain Treatment Delivery (At Least Weekly)

Total Survey

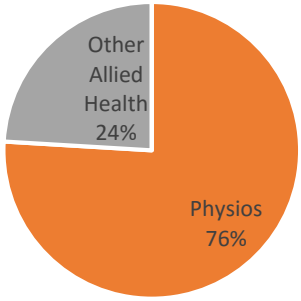


Remote

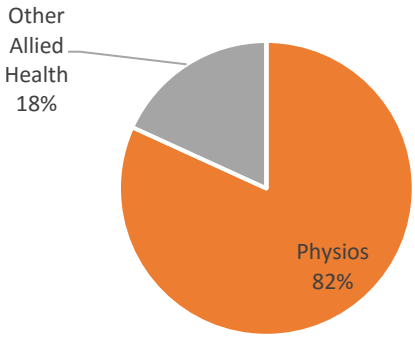


12.4b Pain Treatment Delivery (At Least Four Days Each Week) – Total Survey

Total Survey



Remote



Allied health staff are required to undertake 12.4b complex pain treatments. An analysis of Physiotherapy hours indicates that each 12.4b pain treatment takes approximately 18 minutes. Therapists are therefore spending 1.2 hours each week per resident on pain treatments (excluding time allocated for care planning, treatment set-up or documentation). Results indicate there is minimal capacity to increase the time spent on pain treatments without the requirement for additional therapy resources.

Complex Pain Treatment Time and Allied Health Contribution

Region	Average Treatment Time (minutes)	Time Spend by Physiotherapists on Pain Treatments (%)
ACT	35.83	85%
NSW	13.10	80%
QLD	15.90	99%
SA	23.82	87%
TAS	26.26	44%
VIC	18.99	60%
WA	27.67	57%
Remote	19.0	58%
National	**17.79**	**75%**

Approximately 70% of allied health professionals conducting pain treatments are contractors. This is dependent on the practices of each organisation and the capacity to attract allied health therapists. For example, in Western Australia, for example, there is currently a large supply of allied health practitioners and providers express no difficulty accessing therapists. The cost of contracted allied health staff is significantly higher than the cost of direct employees.

Proportion of Allied Health Contractors Undertaking 12.4b Complex Pain Treatments

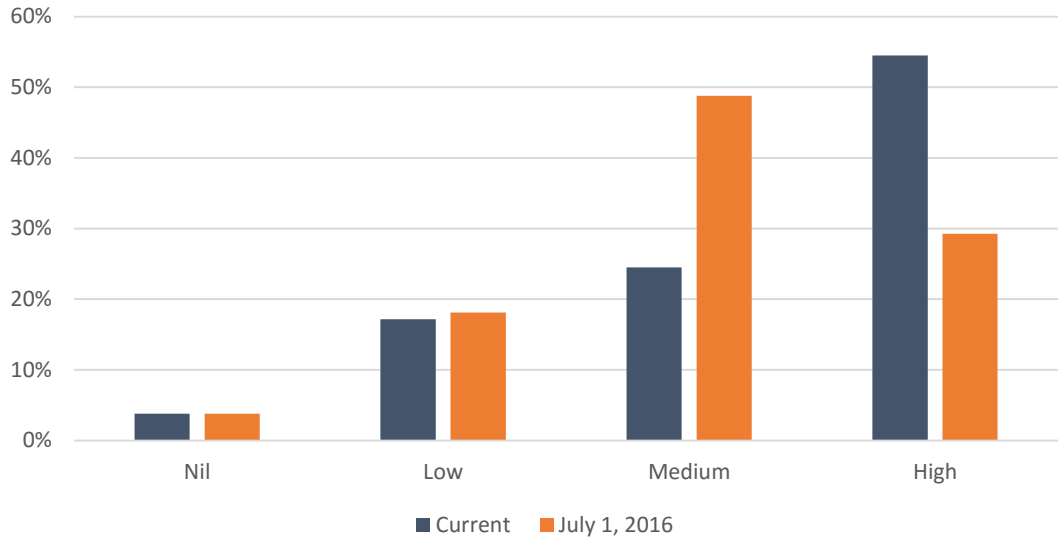
Region	Contractors Undertaking 12.4b Pain Treatments (%)
ACT	100%
NSW	78%
QLD	63%
SA	41%
TAS	100%
VIC	90%
WA	27%
Remote	82%
National	**70%**

6. Effects of Funding Changes on Sustainability

July 1, 2016 Changes

Changes to the scoring matrix that results in the downgrade of two categories in the CHC domain will have a material impact on funding for not-for-profit providers.

Effect of July 2016 ACFI Changes on Domain Scoring



This will have a material impact on residents admitted between July 2016 and January 2017. The not-for-profit facilities included in the survey will receive $1,741 less per annum per resident following the changes.

Effect of July 2016 ACFI Changes on Resident Funding ($)

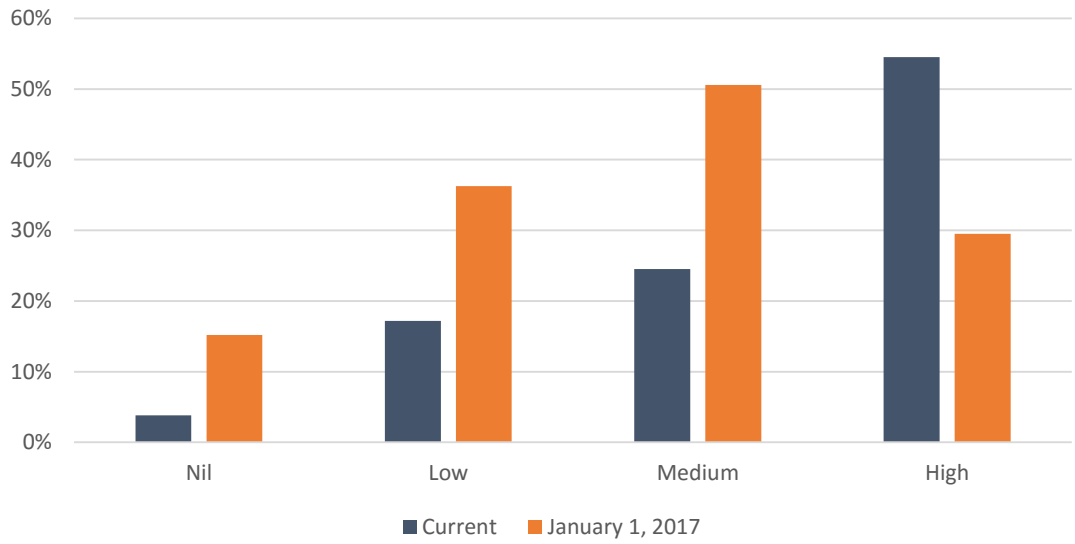
	Resident CHC Funding Change per Day ($)	Resident CHC Funding Change per Annum ($)	Net Change ($) per Resident per Annum Net of ADL & BEH Indexation Increases
Survey	$4.77	$1,741.05	$1,203.92
National	$5.10	$1,890.70	$1,351.05

New or reassessed residents admitted after July 1, 2016

January 1, 2017 Changes

The January 2017 changes will be far more profound as a significant number of residents will shift from the high to medium classification in the CHC domain.

Effect of January 2017 ACFI Changes on Domain Scoring



Each home will receive on average $6,655 per annum less for residents admitted or reassessed after 1 January 2017 following the budget changes. At both a national level and based on the survey group, this represents an 11% decrease in subsidy revenue.

Effect of January 2017 ACFI Changes on Resident Funding ($)

	Resident CHC Funding Change per Day ($)	Resident CHC Funding Change per Annum ($)	Net Change ($) per Resident per Annum Net of ADL & BEH Indexation Increases
Survey	$19.71	$7,192.49	$6,655.35
National	$19.37	$7,069.34	$6,529.69

New or reassessed residents admitted after January 1, 2017

The effects of the cuts will be most profound on homes with high care and complex care needs.

The Impact on Long Term Funding

The effects of the budget cuts will be long lasting. Whilst the changes to the tool only take effect for new or reassessed residents, we anticipate that the vast majority of residents will be affected by the change within three years. The current average length of stay in permanent residential care is less than 35 months.[5] The reassessment of residents due to prolonged hospital stay, extended leave or changes in care requirements will inevitably increase the turnover of grand-parented claims to the reduced rates beyond our projections.

[5] Australian Institute of Health and Welfare Separations from Aged Care 2013-2014.

Projected Cuts 2016 to 2020

	2016-17 ($m)	2017-18 ($m)	2018-19 ($m)	2019-20 ($m)	Total ($m)
National Impact					
Budget/MYEFO Cuts	(206.6)	(358.7)	(511.1)	(629.8)	(1,706.2)
ASPL Estimations					
CHC Funding Cuts (Indexed)	(114.8)	(556.7)	(1,031.8)	(1,223.2)	(2,926.5)
ADL & BEH Funding Increases (Indexed)	93.3	94.5	95.7	97.0	380.4
Net Estimated ACFI Funding Decrease	**(21.5)**	**(462.3)**	**(936.1)**	**(1,126.3)**	**(2,546.1)**
Difference	**(185.1)**	**(103.5)**	**(425.0)**	**(496.5)**	**(839.9)**

The proposed funding cuts appear to be materially underestimated by the Government. Our analysis indicates that the cost of the cuts to the providers will be in excess of $2.5 billion over the next four years alone, which is nearly $840 million more than the Governments' forward estimates.

As the changes are permanent, there will be long-standing cuts that will both affect the care of our most vulnerable residents and affect the long-term viability of residential care providers. We anticipate that the funding cuts will result in a net decrease in ACFI funding in excess of $1.1 billion per annum beyond 2020.

Impact on Sustainability

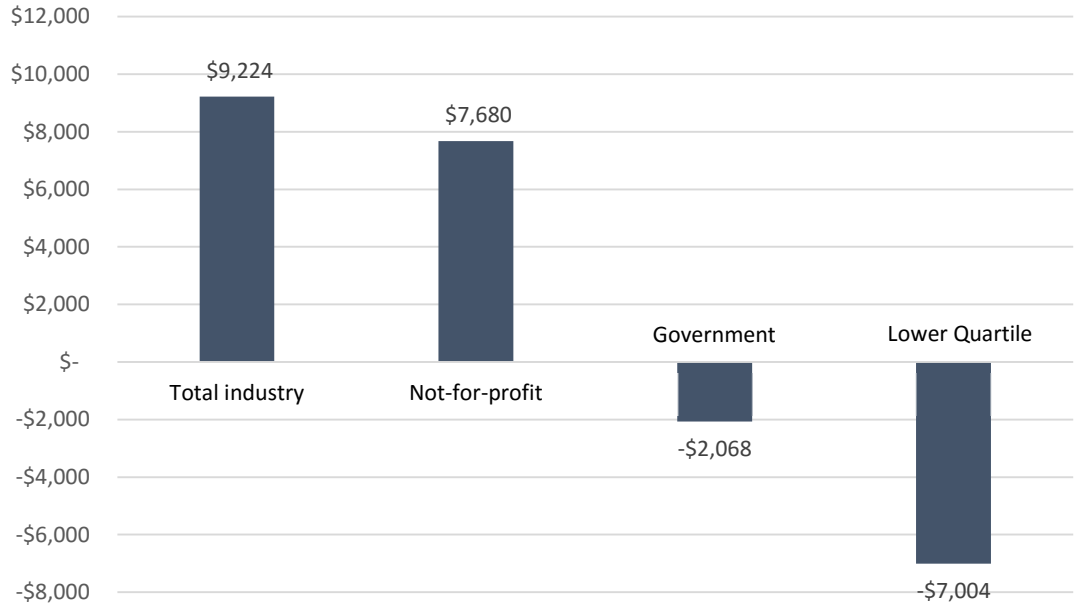
The financial impact of the funding cuts on providers will undermine the viability of the sector.

Data from the Aged Care Financing Authority (ACFA)[6] detailed that the average EBITDA margin for not-for-profit facilities is only 10% and the average profit is $7,680 per bed per annum. At least 25% of the sector are currently making a loss with the lowest performing quartile reporting an average EBITDA loss of $8,866 per bed per annum.

The cutbacks will result in substantial decreases in revenues (an average decrease of 11%) and will result in operating losses for increasing numbers of not-for-profit providers.

[6] Aged Care Financing Authority Third Report on the Funding and Financing of the Aged Care Sector July 2015.

EBITDA – Current (2013/14)



Effects on Remote Facilities

Rural and remote facilities will be perhaps worst affected by the changes, despite additional viability supplements.

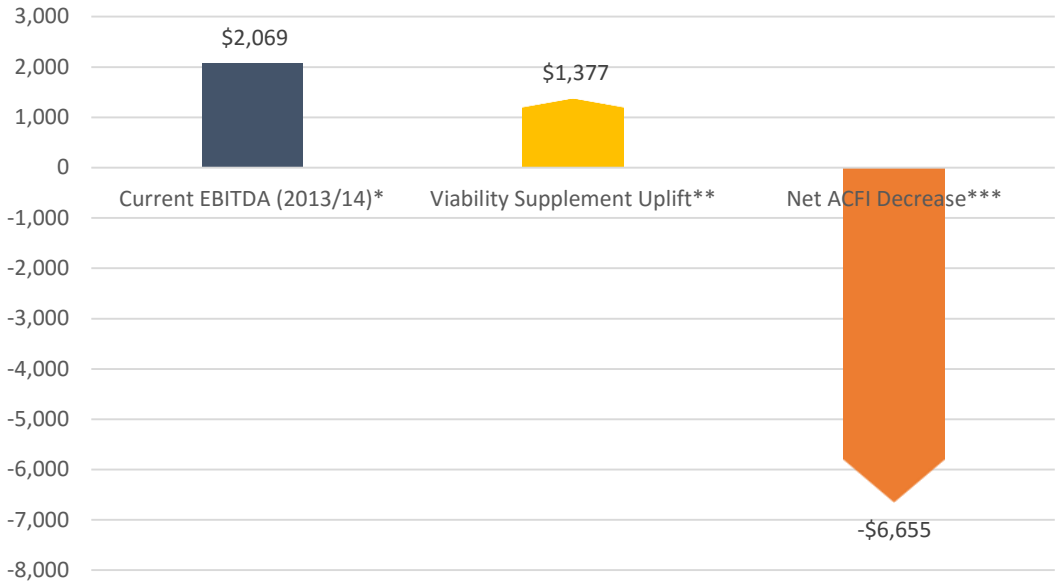
The Government announced that it will provide $102.3 million over four years from 2016-17 to increase the aged care viability supplement. The funding will target the aged care viability supplement more effectively to areas of greatest need by replacing the current outdated remoteness classification system with the more up to date Modified Monash Model. The model is currently used in other health environments and will bring the viability supplement assessment process into line with other health programs.

The effect of the supplement, however, will be diluted across residential care, home care and multi-purpose services throughout Australia resulting in a minimal spend on residents.

On average, rural and remote providers earn an EBITDA of $2,069 per resident per annum. Based on the forwards estimates, the increased viability supplement would provide, at most, approximately $1,400 additional funding per annum, per rural and remote resident (note, the allocation of additional funding between residential aged care and home services has not been provided, therefore for simplicity, we have assumed the full funding amount would be allocated to residential aged care providers).

This is negated by the estimated decrease in ACFI funding and is likely to result in a greater number of rural and remote providers recording unsustainable losses.

Average Annual Impact of Budgeted Changes per Rural & Remote Resident



* ACFA February 2016 Report - Financial Issues Affecting Rural and Remote Aged Care Providers
**Average annual uplift calculated based on total forward estimate $102 million
*** Estimated full impact of budgeted ACFI changes

The Response from Industry

Across the industry, providers and peak bodies have protested against the changes and funding cuts. Participants in the survey were requested to provide their views in relation to the impact of funding cuts and the strategies that would be employed at their home. Summary quotes are provided at Appendix Three.

The most consistent themes from respondents were:

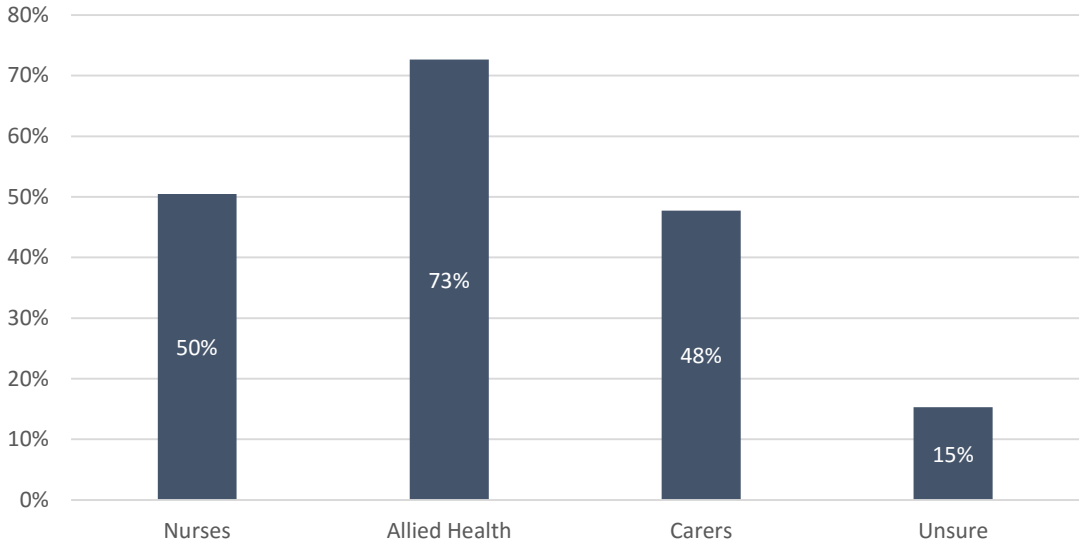
1. Resident admission strategies would be carefully reviewed with many indicating the reluctance to admit residents with highly complex care needs;
2. Clinical and allied health resources would need to be reduced, directly impacting on the quality of care for residents;
3. Whilst care would continue to be delivered on a resident needs basis, some specific programs would have to be cut back or discontinued, particularly those relating to pain management, mobility management and falls prevention;
4. More older people would be expected to be displaced into hospitals; and
5. Major concerns were raised regarding the viability of residential aged care services, particularly rural providers and smaller homes.

Solutions to the problems were also presented by survey respondents. These will form part of the broader submissions to government by UnitingCare Australia.

Survey participants were also asked to consider if they would be likely to change their staffing structures/services as a result of the announced cuts. An overwhelming number of respondents stated they would reduce allied health resources (73%) and more than 50% of

survey participants stated they would be likely to reduce nursing staff. Over 27% of all respondents stated they would reduce nurse, allied health and care staffing/services.

Anticipated Reduction in Staff/Services



This response is in line with the general consensus in the industry that a complete cost benefit analysis of CHC treatments involving nurses or allied health professional will be required going into 2017.

Our analysis of the changes in the 12.4b treatment times from "At least four times a week" to "At least four hours per week and at least 2-hours of duration per week" indicates that the cost of delivering Physiotherapy led pain treatments will increase between 7% and 94%.

Projected Cost of 12.4b Treatments

	Survey Results			Projected Under New Rules	
	Average 12.4b Pain Treatment Time (Minutes per Resident per Treatment)	**Minimum Total Treatment Time Each Week (Hours)[7]**	**Total Cost of Treatment[8]**	**New Minimum Required Treatment Time (Hours)**	**Minimum Total Cost of Treatment Under New Rules**
National	17.79	1.52	$127.54	2.33	$195.83
NSW	13.10	1.21	$96.53	2.33	$186.67
QLD	15.90	1.39	$114.94	2.33	$192.50
SA	23.82	1.92	$182.55	2.33	$221.67
TAS	26.26	2.08	$197.99	2.33	$221.67
VIC	18.99	1.60	$111.97	2.33	$163.33
WA	27.67	2.18	$179.67	2.33	$192.50

[7] Includes 20-minutes allocated for care planning, set-up of treatment, time to assist resident to point of treatment and documentation of treatment attendance and outcomes.

[8] Source: Average Pricing from W&L Wellness and Provider Assist contract therapy services.

7. Conclusion and Next Steps

The analysis demonstrates that the proposed funding cuts would have a devastating impact on aged care providers, particularly those caring for highly vulnerable people with complex care needs.

The study also demonstrates that the financial impacts of the changes are materially greater than originally projected by the Commonwealth. As the DoH is currently in caretaker mode leading up to the Federal Election, we are unable to determine whether the margin is a result of error or is an intentional strategy to curtail future projected subsidy growth.

We also recognise the budgetary challenges created by the ageing population for Government. The Commonwealth projects a $3.8 billion blowout on ACFI spending over the next 5 years.

These challenges to providers and Government reflect the change in the physical demands of residents in residential aged care settings and the advancement of home care services in Australia. It is also a reflection of the maturity of ACFI which was introduced over 8 years ago. In combination, the aged care sector is managing an unsustainable system in which:

1. The ACFI mechanism does not accurately allocate resources based on contemporary resident need. This may result in core activities not being funded and creates potential wastage of resources directed towards lower priority activities that do attract funding; and
2. Increasing frailty among the resident population is creating an escalating burden on the taxpayer because of the funding regime which is heavily subsidised by Government.

The *Living Longer, Living Better* legislation has provided some scope to address inequities within the system and facilitate greater levels of contributions from consumers toward their care. However, the increasing resident dependency levels makes it difficult to achieve balance under the current system. The result is that the 2016 Budget cuts will fall directly upon providers of the care, with no avenues to recover the losses from residents, other than cutting their services.

Obviously, decreasing clinical support for residents with escalating complex care needs in not going to be sustainable. The funding instrument and the wider system must now change.

To address the problem, the system will need to be reengineered to ensure:

- Funding allocations are more accurately reflective of the ***client needs***;
- Clear guidelines are developed to clarify the delineation of ***taxpayer funded services*** to those that require ***co-contributions from consumers***, or supplements from Government;
- Residential aged care and home care funding instruments are combined or aligned to facilitate a ***seamless continuum***; and
- Remaining ***supply limitations*** on aged care series are progressively relaxed to facilitate greater responsiveness to demand from providers and more choice for consumers.

The funding cuts have renewed calls for a comprehensive cost of care study, similar to the research undertaken recently in New Zealand. While this research greatly assisted in the reallocation of funding to emerging areas of client need in New Zealand, the Australian Government will be nervous about the political implications, including the need to address any potential funding shortfall identified.

However, the assessment of relative resourcing for different aged care activities can meet the allocation objective without exposing funding shortfalls. The overall objectives would be to determine the physical needs being addressed in contemporary residential aged care settings and the level of resources committed to addressing those needs.

This will facilitate discussion on priority resource allocations for residents with a diverse range of needs and in a variety of circumstances.

With the evolution of home care, and the deregulation of supply from February 2017, it is timely to consider the integration of residential aged care and home care funding systems. With the emergence of innovative models in home care and retirement living, the harmonisation of funding models will enhance consumer choice and provider responsiveness to need.

As consumers become responsible for contributing greater levels of their own resources toward their care, the aged care sector will become more competitive and innovative.

It will be in this environment that savings will be found for taxpayers in the medium to long term. It will also require investment in change in the short term. We recommend:

1. The proposed funding cuts should be deferred until the Commonwealth has given greater consideration to the impact of the changes to residents, providers and aged care workers as outlined in this report;
2. A taskforce should be established to review the cause of the budget deficits, deficiencies and inequities inherent in the current system and develop a long term sustainable solution;
3. Undertake a comprehensive review of aged care services and the level of resources allocated to core areas of need. Establish clear guidelines to clarify the delineation of taxpayer funded services to those that require co-contributions from consumers, or supplements from the Government; and
4. Develop a new funding instrument for aged care, covering both the residential and home care environments that will facilitate greater balance on investment between providers, consumers and taxpayers.

Appendix One – Glossary

ACFA	Aged Care Funding Authority
ACFI	Aged Care Funding Instrument
ACT	Australian Capital Territory
ADL	Activities of Daily Living
Ansell Strategic	Ansell Strategic Pty Ltd
BGL	Blood Glucose Level
BEH	Behaviour Supplement
BP	Blood Pressure
CHC	Complex Health Care
CPAP	Continuous Positive Airway Pressure Ventilation
DoH	Commonwealth Government Department of Health
DVT	Deep Vein Thrombosis
EBITDA	Earnings Before Interest, Depreciation and Amortisation
IV	Intravenous
DSS	Commonwealth Government Department of Social Services
MYEFO	Mid-Year Economic and Fiscal Outlook
NSW	New South Wales
No.	Number
NT	Northern Territory
Physio	Physiotherapist
QLD	Queensland
Remote	Home located out of metropolitan area receiving the rural and remote viability supplement
RN	Registered Nurse
SA	South Australia
TAS	Tasmania
VIC	Victoria
vs.	Versus or as opposed to
WA	Western Australia

Appendix Two – About ACFI

ACFI assesses core care needs related to day to day, high frequency need for care. These aspects are then used to measure the average cost of care in longer stay environments.

While based on the differential resource requirements of individual persons, the ACFI is primarily intended to deliver funding to the financial entity providing the care environment.

The ACFI consists of 12 questions about assessed care needs across three care domains:

- Activities of Daily Living (ADL):

  Ratings on Nutrition, Mobility, Personal Hygiene, Toileting and Continence questions are utilised to determine the level of the basic subsidy

- Behaviour Supplement (BEH):

  Ratings on Cognitive Skills, Wandering, Verbal Behaviour, Physical Behaviour and Depression questions are utilised to determine the behaviour supplement

- Complex Health Care (CHC):

  Ratings on Medication and Complex Health Care Procedure questions are utilised to determine the complex health care supplement).

Each of the 12 questions have four ratings (A, B, C or D) and two diagnostic sections. The amount of each of these that is payable in respect of a particular resident depends on the ratings (A, B, C or D) for each of the ACFI questions (1–12). Other data such as diagnosis may be relevant to the calculation of subsidy for some questions.

Appendix Three - Survey Respondents Quotes

The below are sample quotes taken from survey respondents.

Nursing Home Action in Response to Cuts

"We will need to consider carefully who we admit more than ever. A thorough assessment will need to be done prior to accepting residents."

"The complex care needs for physiotherapy and exercise physiology would be reviewed and cut even though our falls have reduced dramatically since the program commenced some years ago."

"We will have to reduce pain management services, protective bandaging for oedema, skin integrity management."

"In the medium term we may be forced to be selective and screen potential residents who have complex care needs."

"As we approach person centred care we would like to be able to continue to provide holistic care for our residents and continue to do what we have always done. However we are required to strategically think and structure our facility to remain viable in the future. The funding changes are likely to cut care hours."

"The quality of care will be impacted as those who can't afford to pay won't be offered a bed."

"We will no longer be able to accept residents with complex care needs or people with any multiple medications. Would not take further residents with PEG tubes, insulin management etc."

"We will be unable to provide essential pain management services to our residents and will lose the expertise of full time Physiotherapist."

"…pre-admission will need to be screened thoroughly to ensure services can be delivered for each resident."

"Will need to reconsider which residents are admitted as it will not be possible to continue to provide the same level of care if the funding is cut."

"We will be less likely to accept residents with high complex needs e.g. wounds, pain management, due to the high cost of providing complex care services."

"We may have to transfer high care residents to a different setting for managing safety needs."

"Providers will be forced to review all residents care needs prior to admission to ensure their required services will be financially viable for them."

"Will be sending more resident to hospital and not providing complex treatment in their own environment, we will reconsider admitting potential residents with complex needs."

Implications for the Elderly

"This will affect the quality of care, availability of services and access of the services for residents especially those who are receiving pain management which may severely affect the resident's well-being and quality of life. This will also have repercussions to the resident's behaviours, mobility, independence, emotional health and nutrition. As a likely result, this will increase the frailty and independence of the residents which may also increase their need to visit tertiary care providers such as hospitals."

"Our physiotherapy program is the core of our Living Longer/Living Better initiatives for our residents, to cancel this program would be catastrophic for our residents, impacting pain management, mobility, independence, continence to name just a few unacceptable outcomes."

"...residents with complex pain will most likely be treated by medication which will reflect on service delivery and increased side effects on residents."

"There will be a reduction in pain management services, protective bandaging for oedema, skin integrity management."

"In 25 years I have seen the residents moving into residential care, now arriving at an older age bracket, most with multiple diseases and co-morbidities. These residents require skilled clinical and medical care which will not be available due to reduced funding. This will result in the displacement of residents into acute care settings to enable access to appropriate care thereby creating greater stress on these resources."

"We will rely on medications to reduce pain rather than allied health pain management programs to assist with the treatment of chronic pain."

"My major concern is the viability of our small rural residential care facility in the future with these ongoing cuts. We are not a large aged care provider and if we were forced to close our small rural community would have to send their elderly away from the district, community support and family."

"We may not be able to provide therapeutic treatments to our residents with increased pain due to the cuts because the time required to provide 12.4b is too extensive. Our residents who thoroughly enjoy their treatments will miss out on services that currently reduce their pain and enhance their quality of life."

"We are a rural facility and have been unable to provide allied health pain management programs due to the limited availability of services in our area. With the decrease in the funding available for the RN massage, our facility will be at risk of being unable to provide this service."

"A reduction in the availability of this skilled service may in turn lead to increased resident dependency, reduced resident quality of life and potentially increased hospital transfers."

"Less one-to-time with residents, increase pressure on remaining staff."

"Reduced resourced to enable quality health care (e.g. palliative care, management of oedema, DVT, arthritic joints and chronic skin conditions requiring compression garments, bandages and dressings etc.)."

"It will minimise the level of services provided to our clients as our capabilities to provide these services require adequate funding."

"I will need to consider when admitting residents whether the individuals will require a higher level of care ongoing. Residents will need to be nursed in hospital rather than in the home due to insufficient resources."

"The changes will reduce the services we are able to provide to the most disadvantaged and marginalised residents."

"Will be sending more resident to hospital and not providing complex treatment in their own environment, we will reconsider admitting potential residents with complex needs."

"...reduced carer numbers will result in less time spent with residents and qualitative outcomes will reduce."

"We envisage increased hospitalisations as providers reduce clinical staff."

"We will be unable to provide essential pain management services to our residents and will lose the expertise of full time Physiotherapist."

"We would have to send more residents to the hospital emergency department as we wouldn't have the funds to meet their care needs."

"I think it will be a challenge to deliver consumer directed care with the proposed changes to the budget given the reduction on staffing."

Other Implications for Providers and the Health Sector

"We are a small facility already struggling financially and these changes will reduce our funding and ability to claim funding even more."

"The announcement of funding cuts has redirected the focus to the 'cuts' and not the crisis that has been happening for years in underfunded aged care. Residential aged care will be unable to accept high needs residents requiring more than one staff member to deliver care and therefore the acute hospital system will back up with elderly patients unable to be placed."

"…proposed cuts will have a major impact on our viability. Residents are coming into care later with more complex needs and with poor mobility or behavioural problems. That is why medication claims have increased. That is why complex care has increased."

"The changes will affect our viability and will result in reduction of beds offered to aged care in our rural location."

"Acute services i.e. hospitals/ambulance, will see the impact of the reduction in wellness programs and withdrawal of complex care management from residential homes."

"Our elderly deserve to have treatments and quality services that make their end of life the best possible. We in aged care are not here for the money. As we all know it is one of the lowest paid industries. We do this because we care about our elders."

"If we can't break even or make a profit aged care will not be sustainable and will need to close doors."

"Impact on regional, remote and rural providers is significant. Again, the Government bases all decisions on major population centres and fails to recognise the impact of their broad brush approach."

"Huge impact on staff losing their jobs/security, resident's care standards will be compromised, hospitals will be full of aged care residents."

"Registered Nurses will be utilised back in direct care, instead of being able to provide sound clinical governance and direction."

"We often take people that other residential care facilities will not accept into their services. Medication administration is complex and time consuming….As many of our clients have early onset dementia they do not always have the claimable complex needs…"

"Less one-to-time with residents, increase pressure on remaining staff."

"…as a facility we will be reactive rather than proactive to our interventions."

"Increased reliance on external service providers – palliative care units, rapid response teams, would management specialists and hospital admissions."

"Work-related stress for nurses and carers, a high turnover among nurses, an increase number of complaints from unsatisfied residents and their relatives, an increase number of transfers to hospital, a reduced funding to provide appropriate level of care and sufficient amount of equipment, supply for nursing service and treatment."

"Reduced staffing numbers and higher stress levels."

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